TRICARE Management Activity
Uniform Business Office

Denial Management – Tools, Tips, and Solutions

Presented by
TMA UBO Program Office Contract Support

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Objectives

- Learn how to read and understand an Explanation of Benefits (EOB)
- Recognize reasons for denials
- Learn ways to communicate effectively with insurance carriers and payers
- Learn ways to communicate effectively with coders and Patient Administration Directorate (PAD) staff to produce clean claims
- Understand medical necessity denials
- Learn how to measure success
- Gain basic understanding of rules that apply to Third Party Collection Program (TPCP) denials management
- Learn how effective denials management reduces TPCP Aged Accounts Receivables

Sample Explanation of Benefits (EOB)

EXPLANATION OF BENEFITS

SAMPLE

Dec 01, 2005

Group Number: 12345678
Member: John Sample
Member's ID: 10000017-01
Claim Number: 8000000001
Provider: Smith, Robert
Payment Reference ID: 2002062510100013

(This Is NOT a bill)

1 Service/ product description	2 Dates you received service/product (m/d/y to m/d/y)	3 Charges billed by provider	4 Minus provider's fee adjustment (*)	5 Minus your copay (C), deductible (D) or amount not covered (**)	6 Total amount eligible for benefits	7 %	8 Minus your coinsurance amount	9 Plus or (minus) adjustment	10 Total paid by your plan	11 Amount you're responsible for
OFFICE VISIT	11/15/05 11/15/05	75.00	12.00 PDC	15.00 C	48.00	100%			48.00	15.00
LAB	11/15/05 11/15/05	89.12	15.36 PDC	50.00 D	23.76	100%			23.76	50.00
X-RAY	11/15/05 11/15/05	100.00	20.00 PDC		80.00	80%	16.00		64.00	16.00
SURGERY	11/15/05 11/15/05	50.00		50.00 575	0	0%			0.00	50.00
Totals		$314.12	$47.36	$115.00	$151.76		$16.00		$135.76	$131.00

Amount you're responsible for: $131.00

Your 2005/Plan Year Medical Deductible satisfied so far: $100.00
Your 2005 Plan Year Family Medical deductible satisfied so far: $300.00
Amount you're responsible for: $131.00

Message Codes:
PDC AGREEMENT DISCOUNT
575 THIS PROCEDURE IS CONSIDERED COSMETIC. YOUR PLAN DOESN'T COVER COSMETIC SERVICES.
Z48 NOTE: WHEN YOU RECEIVE SERVICES FROM A NON-PREFERRED PROVIDER, WE MAY PAY BENEFITS DIRECTLY TO YOU. IF SO, YOU WILL NEED TO MAKE ARRANGEMENTS TO REIMBURSE THE PROVIDER.
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AlaskaCare Health Plans

Premera Blue Cross Blue Shield of Alaska

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Sample EOB, Definitions

1) **Service/product description**—what services the patient received from the provider
2) **Dates patient received service/product**—when the patient received services (month/day/year to month/day/year)
3) **Charges billed by provider**—amount billed to the patient and your health-care plan(s)
4) **Provider's fee adjustment**—difference between "charges billed by provider" and the amount providers have agreed to accept as full payment; see "Message Codes" at the bottom of your EOB for details
5) **Copay, deductible or amount not covered**—"copay" is the amount the patient pays the provider for a visit/service; "deductible" is the amount the patient pays toward covered services each year before the third party payer starts paying for services unless services are covered without applying the deductible; "amount not covered" applies to services/products not covered by the plan; see "Message Codes" at the bottom of the EOB for details.

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Sample EOB, Definitions cont.

6) **Total amount eligible for benefits**—charges billed by provider minus provider fee adjustment minus patient copy, deductible or amount not covered
7) **%**—percentage level of benefits for covered services/products
8) **Patient coinsurance amount**—what the patient must pay the provider after we pay the covered percentage
9) **Adjustment**—see explanation(s) at the bottom of the EOB for details. **Total paid by your plan**—"total amount eligible for benefits minus coinsurance amount
10) **Amount patient responsible for**—what the patient must pay of the billed charges after the plan benefits are paid

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Reasons for Denials

- Non participating provider
- Medicare EOB required
- Incorrect dates of service
- Procedure or service not medically necessary
- Pre-Existing condition
- Non-covered benefit
- Termination of coverage
- Failure to obtain preauthorization
- Out-of-network provider used
- Lost claims
- Missing plan code or group number
- Timely filing
- Incorrect dates of service
- Wrong revenue codes or occurrence codes
- Incorrect or missing place of service
- Incorrect NDC code or expired NDC code

Communication with Payer Representative

- Read the EOB carefully
- Call the carrier if a denial reason needs clarification
- If payer representative gets impatient, ask to speak with the manager
- Consider the denial could be applicable to contract providers not MTFs
- Get specific instructions about where to send the appeal and what supporting documents are required
- If carrier maintains the denial and you believe the carrier is not meeting the terms of the policy, forward to your servicing legal department

Communication Between Billers and Coders

- Accurate coding is required for proper payment from insurance companies and other payers
- Build a good relationship with coders so you can produce clean claims
- Build good relationships with your Patient Administration Directorate (PAD) staff. If they enter incorrect information in CHCS at the front end, you may never see a claim for that beneficiary
- Billers need to share and communicate with coders in order for coders to understand how coding affects the reimbursement process and is required for clean claims
- Billers need to understand what a clean claim looks like. Learn the basics of coding so you can recognize when codes may or may not be correct and know why the coder used that particular code
- Set up meetings and training so coders and billers can learn together

Understanding Medical Necessity Denials

- Clean claim requires ICD diagnosis code(s) that shows medical necessity of service/item
- Insurers generally reserve the right to determine whether a service or supply is medically necessary
- A physician's prescription, order, recommendation, or approval of a service/item does not guarantee it's medically necessary or a covered service/item
- All inpatient admissions must be pre-certified
- Outpatient services/items may require pre-certification:
  1. All same day surgeries and ambulatory procedure visits (APVs)
  2. Some prescription drugs
  3. Some radiology procedures or tests
  4. Some laboratory tests
- Insurance companies list procedures and supplies that require "precertification" on their Web site and in their benefit plan brochure

Measuring Success

- Monthly review of Accounts Receivable (AR)
  - Review dollar amounts for all outstanding accounts
    - Reasonable goal: all accounts in AR are < 60 days
  - Must follow-up and either close or transfer accounts to DFAS
- If Aged accounts have not been followed up on, you will see a very large number on your AR report
- Reconcile AR monthly with Financial Services Office (FSO) or Budget Offices
- Ensure current effective rates are updated in CHCS and TPOCs or your Billing System
  - TMA UBO Outpatient Itemized Billing (OIB) rates revised annually and generally effective 1 July
  - TMA UBO Inpatient Adjusted Standardized Amounts (ASAs) revised annually and generally effective 1 October

Rules that Apply to TPCP

- Use DD Form 2569 to capture patient Other Health Insurance (OHI) information
  - OHI is any insurance patient may carry issued by employer or private insurance company
  - All non-Active Duty patients are required to complete it every 12 months or if data changes
  - OHI needs to be entered into CHCS or it “doesn’t exist” for billing purposes
  - All billable patients must have a current DD Form 2569 in their patient record
    - *Examples: civilian emergencies, embassy personnel, secretarial designees (e.g., senators, congresspersons, President)*

10 U.S.C 1095 and 32 C.F.R. 220

- Title 10, United States Code, Section 1095
  - Authorizes the government to collect reasonable charges from third party payers for health care provided to beneficiaries.

- Title 32, Code of Federal Regulations, Part 220
  - Implements 10 U.S.C. 1095 and specifies:
    - Statutory obligation of third party payers to pay; no assignment of benefits required
    - Certain payers excluded from the TPCP
    - Applicable charges
    - Rights and obligations of beneficiaries
    - Special rules for Medicare supplemental plans, automobile insurance, and workers' compensation programs

Tips for Submitting Clean Paper Claims

- Try to file your claims electronically, but if you must file paper claims:
  - Use only original claim forms
  - Make sure claims are printed darkly
  - Avoid folding claims, if possible
  - Avoid using terms such as “re-filed claim,” or “second request”
  - Avoid handwritten claims
  - Don’t use all UPPERCASE letters
  - Don’t use punctuation or decimals
  - Don’t send unnecessary attachments
  - Don’t use staples, paperclips or post-it notes
  - Don’t mark up the claim with highlighters
  - Don’t use circles or additional markings
  - Don’t attach labels or stickers
  - Don’t add notes or instructional assistance
- Remember that insurance companies scan all claim forms

Summary

- Remember to use the correct collection authority on all your correspondence – 10 USC 1095 and 32 CFR 220
- Documentation is very important
- Always escalate your call to a manager, especially when an appeal may involve a large quantity of claims
- Be patient and have a strategic plan
  - Make sure your claims are ‘clean’ before you send them
- Obtain health insurance benefits information to properly identify valid and invalid denials
- An effective Denials Management Program reduces your Aged AR and increases your collected-to-billed ratio

Resources

- UBO Web site
  - http://www.tricare.mil/ocfo/mcfs/ubo/index.cfm

- UBO Help Desk Contact Information
  - ubo.helpdesk@altarum.org
  - 571-733-5935

Questions & Answers

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